Opening Statement of Representative Kenny Hulshof
Committee on Ways and Means, Subcommittee on Health
May 15, 2007

Mr. Chairman, I'm grateful that you have called this hearing. Fee-for-Service Medicare financing is one of the most pressing responsibilities of this Committee, and how beneficiaries receive treatment within the post-acute care setting is a vital piece of inpatient care.

As you know, Mr. Tanner and I have introduced legislation, H.R. 1459, which addresses post-acute care in the Inpatient Rehabilitation Hospital, or IRF, setting. In recognizing that IRF admissions goals hoped for in drafting the so-called 75% Rule have been achieved, H.R. 1459 keeps that rule at the current 60% threshold. As of today the bill has 151 cosponsors, and we're adding cosponsors every day

Our biggest concern about the 75% rule is the seemingly arbitrary effect it has on patients, specifically patients who are not within the 13 diagnostic categories that "count" toward the 75%, including cardiac, pulmonary, cancer, pain, and joint replacement. Patients outside the 13 qualifying conditions are often denied IRF access, and access is most restrictive for patients whose needs benefit from

newer rehab specialties such as pulmonary, cardiac and cancer.

A Moran Report published this month demonstrates the precipitous drop already seen in the IRF setting: in the four quarters ending in Quarter 1 of 2007, Medicare volume totaled 255,006, down 23.5% from the 333,559 discharges in the same period ending in Quarter 1 of 2004. That's an almost 80,000 reduction in discharges in 3 years. The admissions criteria rule has achieved its goal, and it needs to be maintained at 60%, or we risk doing irreparable harm to constituent access to inpatient rehab.

Mr. Chairman, for all these reasons, we need to be paying close attention to what's happening with the 75% Rule. 2 years ago, we held a similar hearing and heard from CMS, from Mr. Kuhn, and I look forward to the update we will hear from him today. It was discussed at that hearing 2 years ago that the rule's impact on access may have been overstated, because the "high-water mark" where a spike in admissions to rehabilitation hospitals had occurred due to the suspension of the old 75% Rule. But in the past 2 years the 75% Rule produced a fairly harsh picture, both for rehabilitation hospitals and for patients who have rehabilitative care needs: we're seeing patient case declines in rehabilitation hospitals in the

neighborhood of 20% or more, not basing it on the "high-water mark."

If this rule remains on its current trajectory toward the 75% threshold, and the comorbidities policy disappears – and by the way, I think CMS needs to carefully evaluate its decision in the FY '08 IRF PPS proposed rule to discontinue comorbidity cases as compliant cases – I'm concerned we're going to see a situation where many people who need and deserve inpatient rehabilitation aren't going to get it.

Mr. Chairman, I'm not comfortable with the 75% Rule. 2 years ago in our post-acute care hearing I said we need to move toward a system that places more emphasis on the specific functional and medical aspects of patients. I still believe that. But, that is going to take research; that is going to require some resource expenditure; and it is going to require people who think their mousetrap is the best mousetrap and nothing else will do, to be open-minded to change – all of which is another way of saying it is going to take some time to get there.

Until we get there, though, the 75% Rule will still be with us. And so we need to really ask ourselves if we are comfortable with leaving it on a trajectory toward full implementation. Keep in mind, Congress

assumed jurisdiction over half this rule – its percentage threshold – when we extended the 60% threshold by an additional year in the DRA. Even if CMS wanted to, it can't alter that threshold percentage – it is a matter of legislative law, not regulation. So we have a role here.

Mr. Tanner and I have introduced H.R.1459 – not to repeal the rule; not to turn back the clock and lower the threshold percentage; not to expand it or otherwise modify it – but to simply keep it where it is. And let's make no mistake about it: where this rule is, is keeping rehabilitation hospitals on their toes and watching who they're admitting like they never have before. I think the position that Mr. Tanner and I have taken in H.R. 1459 is a balanced approach that will allow CMS's policy aims in this area to continue being achieved in a reasonable fashion.

This hearing is an important one, as we're looking to determine our priorities and objectives to deal with Medicare Part A this year. It is my hope that to the extent this Subcommittee, and the full Committee, may report a bill addressing Part A, we will include H.R.1459's provisions in that report.